

**United States Park Police**  
**STANDARD MEDICAL HISTORY AND EXAMINATION FORM**

USPP form 130C

D4H\_\_IN20525

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**\*\*\* CAUTION \*\*\***

WHEN COMPLETED, THIS DOCUMENT CONTAINS  
CONFIDENTIAL  
MEDICAL INFORMATION

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*US Park Police Occupational Health Services:* Please: 1) complete the box in the lower left corner of page 2 and reference a preplacement or periodic incumbent exam.

**PERSON RECEIVING EXAM:** Please complete ONLY THE SHADED PORTIONS of ALL of the following pages of this form, and take the entire packet to the clinic at the time of your appointment at the address noted below. Note: In order to avoid delays in the review of your exam, please provide full explanations or clarifying information for all "Yes" responses in the medical history portions of this form.

**EXAMINING PHYSICIAN:** Please complete all of the appropriate portions of the form on pages 2,4, and 6. Please note that for pages 4 through 8, *ONLY* those position- and clearance-specific tests and services specified on pages 2 are to be carried out and recorded on the form.

**NOTE: PLEASE PROVIDE FULL EXPLANATIONS OR CLARIFYING INFORMATION FOR ALL "ABNORMAL" FINDINGS OR "YES" RESPONSES ON THE HISTORY. THE GOAL IS TO ASSURE THAT THE REVIEWING MEDICAL OFFICER HAS ALL OF THE NECESSARY INFORMATION TO CARRY OUT THE AGENCY'S OCCUPATIONAL HEALTH REVIEW FUNCTIONS.** When complete, please return a copy of this form and copies of any associated forms and reports to the Reviewing Medical Officer shown below.

# USPP Occupational Health Services Program -- Medical History and Examination Form

The individual to be examined is to complete the shaded medical history portions of this form prior to his/her appointment.

The examining physician/clinic is to attach a copy of this form and copies of screening, diagnostic, and/or laboratory tests, and send them as a package to the addressee checked on page 1 of this form.

|   |                            |  |
|---|----------------------------|--|
| Name, address, and phone number (including fax) of physician/ health center performing examination: |                            | <b>New Applicants ONLY:</b><br>Your Current Occupation:<br><br>Your Current Employer:<br><br>Time in Current Position (in years/months): |
| <b>Name of Agency:</b>  |                            |  |
| <b>Examinee's Name:</b>   | <b>Position/Job Title:</b> | <b>Number of years:</b>  |
| <b>Address:</b>   | <b>Work Location:</b>      | <b>SS#</b>   |
|   | <b>Home Phone:</b>         | <b>Region:</b>   |
| <b>Date of Scheduled Exam:</b>  | <b>Date of Birth:</b>      | <b>Work Phone:</b>   |
| <b>Date of Birth:</b>   |                            | <b>Gender:    Male <input type="checkbox"/>    Female <input type="checkbox"/></b>   |

**DOI OHS PROGRAM MANAGER**

**EXAMINING PHYSICIAN (Please Note - Core Exam must Always Be Completed)**

## PREPLACEMENT-

**Required services to complete exam::**

- ☐ Authorization for Disclosure Form (PAGE 8)
- ☐ General Medical History
- ☐ General Physical Exam
- ☐ Blood Pressure, Height and Weight
- ☐ Chemistry Panel, CBC, Urinalysis Quest # 300551
- ☐ Thyroid profile -Quest # 867 & 899
- ☐ Vision Screening (Corrected & uncorrected, near/far, Color, Peripheral, Depth Perception)
- ☐ Audiometry (500-8000Hz)
- ☐ Electrocardiogram
- ☐ Spirometry
- ☐ TB Skin test (Mantoux)

This examination does not substitute for a periodic health examination conducted by your private provider. It is being conducted for occupational purposes

## PERIODIC-INCUMBENT EXAM

Required Services: (Check those services completed)

- ☐ Authorization for Disclosure Form (page 8)
- ☐ General Medical History
- ☐ General Physical Examination
- ☐ Chemistry Panel, CBC, and Urinalysis-Quest #300551
- ☐ Thyroid panel - Quest #867 & 899 **As baseline only**
- ☐ Blood Pressure, Height and Weight
- ☐ Audiogram 500-8000 Hz
- ☐ Electrocardiogram
- ☐ Spirometry
- ☐ Vision Screening (Corr. and Uncorr. Near/Far; Color; Peripheral; Depth Perception)

## OPTIONAL

- ☐ Chest x-ray – RMO request only
- ☐ Flu vaccine upon request
- ☐ Hepatitis B Vaccine (if previous training)
- ☐ Blood Lead/ZPP (For Firearms Instructors)
- ☐ Stress EKG (at RMO request only)

## FITNESS FOR DUTY EXAM – W108537

Required Services: (Check those services completed)

- ☐ Authorization for Disclosure Form (page 8)
- ☐ General Medical History
- ☐ General Physical Examination
- ☐ FOH Profile
- ☐ Thyroid panel – Free T-4 + TSH
- ☐ Blood Pressure, Height and Weight
- ☐ Audiogram 500-8000 Hz
- ☐ Electrocardiogram
- ☐ Vision Screening (Corr. and Uncorr. Near/Far; Color; Peripheral; Depth Perception)

## PAST MEDICAL HISTORY

(Please complete this page using space at right for details.)

Check each item “Yes” or “No”. Every item checked “Yes” must be explained in the blank space at the right.

- A. Have you ever been treated for a mental condition? (If Yes, specify when, where, and give details.) ☐ Yes ☐ No
- B. Have you had or have you been advised to have any operation? (If Yes, specify when, where, why, name of doctor, and complete address of hospital.) ☐ Yes ☐ No
- C. Have you ever been a patient in any type of hospital after infancy? (If Yes, specify when, where, why, name of doctor, and complete address of hospital.) ☐ Yes ☐ No
- D. Have you ever had any serious illness of injury other than those already noted? (If yes, specify when, where, and give details.) ☐ Yes ☐ No
- E. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past year for other than minor illness? (If Yes, give complete address of doctor, hospital, clinic, and details of problem.) ☐ Yes ☐ No
- F. Have you ever been rejected for military service because of physical, mental, or other reasons? (If Yes, give date and reason for rejection.) ☐ Yes ☐ No
- G. Have you ever been discharged from military service because of physical, mental, or other reasons? (If Yes, give date, reason, and type of discharge, whether honorable or other than honorable.) ☐ Yes ☐ No
- H. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If Yes, specify what kind, granted by whom, what amount, when, and why.) ☐ Yes ☐ No

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

|   |  |  |                            |  |                                 |
|---|--|--|----------------------------|--|---------------------------------|
| <div>MEDICAL HISTORY</div> <div>Have you ever experienced any of the following:</div>   |  | <div>DIAGNOSTIC AND PHYSICAL FINDINGS</div>  |                            |  |                                 |
| <div><div>VASCULAR</div><div>Enlarged superficial veins, phlebitis, or blood clots</div><div>Anemia</div><div>Hardening of the arteries</div><div>High Blood Pressure</div><div>Stoke or Transient Ischemic Attack (TIA)</div><div>Aneurysms (Dilated arteries)</div><div>Poor circulation to hands and feet</div><div>White fingers with cold/vibration</div><div>MD comments on positive findings</div></div> <div><div>Yes</div><div>No</div></div>  |  | <div><div>Cardio/Pulmonary</div><div>Normal</div><div>Abnormal</div><div>Lungs/Chest</div><div>Heart (thrill, murmur)</div><div>Vascular (varicosities, stasis, insufficiency)</div><div>EKG - Attach with interpretation</div><div>Stress EKG - Bruce Protocol, attach with interpretation</div><div>MD Comments on positive findings</div><div>Pulmonary Function Testing: (Attach Copy)</div><div>Calibration Date (same day as test)</div><div>Machine Brand</div></div> |                            | <div><div>CHEST X-RAY</div><div>Last PA Chest X-ray: Date</div><div>Result: Normal Abnormal</div><div>Comments:</div><div>TB Mantoux (PPD) Date planted: Date Read:</div><div>mm Induration:</div><div><div>VITAL SIGNS</div><div>Height (inches) Weight (pounds)</div><div>Blood Pressure / mm/hg</div><div>Pulse /MIN</div><div>Respirations /MIN Temp(if indicated)</div></div></div> |                                 |
| <div><div>RESPIRATORY</div><div>Asthma(including exercise induced asthma)</div><div>Bronchitis</div><div>Emphysema</div><div>Acute or chronic lung infections</div><div>Wind pipe or lung surgery</div><div>Collapsed lung</div><div>Scoliosis (curved spine) with breathing limitations</div><div>History of Tuberculosis</div><div>Previous positive TB skin test?</div><div>Date:</div></div> <div><div>Yes</div><div>No</div></div>   |  | <div>Actual FVC</div>  | <div>Actual FEV1</div>     | <div>Actual FEV1/FVC</div>   | <div>Actual FEF 25-75</div>     |
|   |  | <div>%Predicted FVC</div>  | <div>%Predicted FEV1</div> | <div>%Predicted FEV1/FVC</div>   | <div>%Predicted FEF 25-75</div> |
|   |  | <div>Comments on positive Findings</div>   |                            |  |                                 |
| <div><div>HEART</div><div>Heart pain (Angina)</div><div>Heart rhythm disturbance or palpitations (irregular beat)</div><div>History of Heart Attack</div><div>Organic heart disease (including prosthetic heart valves, mitral stenosis, heart block, heart murmur, mitral valve prolapse, pacemakers, Wolf Parkinson White (WPW) Syndrome, etc.)</div><div>Heart surgery</div><div>Sudden loss of consciousness</div><div>Other (specify)</div></div> <div><div>Yes</div><div>No</div></div> |  | <div>Cardiac Risk Profile (record here, or attach report)</div> <div>Chol HDL LDL Trig Gluc</div> <div>Attach copy of complete blood count (CBC) report, including differential</div> <div>Comments on positive Findings</div>   |                            |  |                                 |
|   |  | <div><div>CORONARY RISK FACTORS</div><div>Blood Pressure <math>\geq</math> 145/90</div><div>Fasting Glucose <math>\geq</math> 120 mg/dl</div><div>Total Cholesterol <math>\geq</math> 200 mg/dl</div><div>Family history of CVD in members <math>\leq</math> 55</div><div>Obesity</div><div>No regular exercise program</div><div>Currently smoking or <math>\geq</math> pack/yr history</div></div> <div><div>Yes</div><div>No</div></div>                                  |                            |  |                                 |
| <div>Describe Your Physical Activity or Exercise Program(check one)</div> <div>Intensity: Low Moderate High</div> <div>Activity</div> <div>Duration, in Minutes per Session</div> <div>Frequency Days per week</div>  |  |  |                            |  |                                 |

| MEDICAL HISTORY  |                          |   | DIAGNOSTIC AND PHYSICAL FINDINGS |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
|--|--------------------------|---|----------------------------------|-----|--|--|--------------------------|---------------------------|------------------|--------------------------|--|---------------|--------------------------|--------------------------|---------------------|--------------------------|---------------------------------|---------------------------------|--------------------------|--|----------------------------------|-----------------------------|---|-------------------------|--------------------------|--------------------------|--------------------------------|--|--------------------------|------------------------------|-------------------------------|--------------------------|--|--|--|--|------------------------------------|--|--|--|--|--|---|
| <div>WELLNESS/HEALTH PROFILE</div> <div>Smoking History</div> <p>This information is needed since smoking increases your risk for lung cancer and several other types of cancer, chronic bronchitis, emphysema, asbestos related lung diseases, coronary heart disease, high blood pressure, and stroke. Please check your smoking status and complete that section:</p> <div><input type="checkbox"/> Current Smoker</div> <div>Number of cigarettes per day</div> <div>Number of cigars per day</div> <div>Number of pipe bowls per day</div> <div>Total years you have smoked</div> <div><input type="checkbox"/> Former Smoker</div> <div>Years since quitting</div> <div>Number of cigarettes per day</div> <div>Number of cigars per day</div> <div>Number of pipe bowls per day</div> <div>Total years you smoked</div> <div>Alcohol/Drug Use</div> <p>What is your average alcohol consumption (number) in a week?</p> <div>Drinks</div> <p>(1 drink = 12 Oz. beer, 1 glass wine or 1.5 oz liquor)</p> <p>How often do you drink alcohol?</p> <div><input type="checkbox"/> Weekdays</div> <div><input type="checkbox"/> Weekends</div> <div><input type="checkbox"/> Both</div> |                          | <div>RESPIRATOR CLEARANCE QUESTIONS</div> <p>What type of respirator do/will you use:</p> <div><input type="checkbox"/> Cartridge</div> <div><input type="checkbox"/> Air Supply</div> <div><input type="checkbox"/> SCBA</div> <p>How often do you use a respirator?</p> <div><input type="checkbox"/> Daily</div> <div><input type="checkbox"/> Weekly</div> <div><input type="checkbox"/> Monthly</div> <div><input type="checkbox"/> &lt; two times a year</div> <p>Effort while using respirator?</p> <div><input type="checkbox"/> Light</div> <div><input type="checkbox"/> Moderate</div> <div><input type="checkbox"/> Heavy</div> <p>Hazards present during use?</p> <div><input type="checkbox"/> High altitude</div> <div><input type="checkbox"/> Temp extremes</div> <div><input type="checkbox"/> Confined spaces</div> <p>Have you ever had, or do you now have any of the following? Please check all that apply and use the space below to comment on positive responses.</p> <table><tr><td>Yes</td><td>No</td><td></td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Persistent Cough</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heart Trouble</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Shortness of breath</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>History of fainting or seizures</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Fear of tight or enclosed spaces</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Sensation of smothering</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heat exhaustion or heat stroke</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Contact lenses or eyeglasses</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other conditions that might interfere with respirator use or result in limited work activity</td></tr></table> <p>Discuss “Yes” responses with the examining physician.</p> |                                  | Yes | No                                     |  | <input type="checkbox"/> | <input type="checkbox"/>  | Persistent Cough | <input type="checkbox"/> | <input type="checkbox"/>                                       | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/>        | History of fainting or seizures | <input type="checkbox"/> | <input type="checkbox"/>   | Fear of tight or enclosed spaces | <input type="checkbox"/>    | <input type="checkbox"/>  | Sensation of smothering | <input type="checkbox"/> | <input type="checkbox"/> | Heat exhaustion or heat stroke | <input type="checkbox"/>                               | <input type="checkbox"/> | Contact lenses or eyeglasses | <input type="checkbox"/>      | <input type="checkbox"/> | Other conditions that might interfere with respirator use or result in limited work activity | <div>Examination Comments/Findings for any/all topics on this page:</div> <div>Comments on positive Findings</div> |  |  |                                    |  |  |  |  |  |   |
| Yes  | No                       |   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Persistent Cough  |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Heart Trouble   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Shortness of breath   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| <input type="checkbox"/>   | <input type="checkbox"/> | History of fainting or seizures   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Fear of tight or enclosed spaces  |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Sensation of smothering   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Heat exhaustion or heat stroke  |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Contact lenses or eyeglasses  |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| <input type="checkbox"/>   | <input type="checkbox"/> | Other conditions that might interfere with respirator use or result in limited work activity  |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| <div>ENDOCRINE</div> <table><tr><td>Diabetes (insulin requiring; units per day )</td><td>Yes</td><td>No</td></tr><tr><td>Diabetes (non-insulin requiring)</td><td></td><td></td></tr><tr><td>Childhood Onset Diabetes</td><td></td><td></td></tr><tr><td>Thyroid Disease</td><td></td><td></td></tr><tr><td>Obesity</td><td></td><td></td></tr><tr><td>Unexplained weight loss or gain</td><td></td><td></td></tr></table>   |                          | Diabetes (insulin requiring; units per day )  | Yes                              | No  | Diabetes (non-insulin requiring)       |  |                          | Childhood Onset Diabetes  |                  |                          | Thyroid Disease  |               |                          | Obesity                  |                     |                          | Unexplained weight loss or gain |                                 |                          | <div>OBSTETRIC</div> <table><tr><td>Are you currently pregnant?</td><td>Yes</td><td>No</td></tr><tr><td></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr></table> <div>MD comments on positive findings</div> |                                  | Are you currently pregnant? | Yes   | No                      |                          | <input type="checkbox"/> | <input type="checkbox"/>       | <div>Attach copy of blood chemistry panel report</div> |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Diabetes (insulin requiring; units per day )   | Yes                      | No  |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Diabetes (non-insulin requiring)   |                          |   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Childhood Onset Diabetes   |                          |   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Thyroid Disease  |                          |   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Obesity  |                          |   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Unexplained weight loss or gain  |                          |   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Are you currently pregnant?  | Yes                      | No  |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
|  | <input type="checkbox"/> | <input type="checkbox"/>  |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| <div>MENTAL HEALTH</div> <table><tr><td>History of psychosis</td><td>Yes</td><td>No</td></tr><tr><td>Psychiatric/psychological consultation</td><td></td><td></td></tr><tr><td>Poor adaptation to stress</td><td></td><td></td></tr><tr><td>Panic attacks, hyperventilation, or anxiety or phobia disorder</td><td></td><td></td></tr><tr><td>Uncontrollable rage</td><td></td><td></td></tr><tr><td>Claustrophobia</td><td></td><td></td></tr><tr><td>Diagnosed depression, personality disorder, or neuroses</td><td></td><td></td></tr></table>   |                          | History of psychosis  | Yes                              | No  | Psychiatric/psychological consultation |  |                          | Poor adaptation to stress |                  |                          | Panic attacks, hyperventilation, or anxiety or phobia disorder |               |                          | Uncontrollable rage      |                     |                          | Claustrophobia                  |                                 |                          | Diagnosed depression, personality disorder, or neuroses  |                                  |                             | <div>DERMATOLOGY/ALLERGY</div> <table><tr><td>Sun sensitivity</td><td>Yes</td><td>No</td></tr><tr><td>Allergic dermatitis to rubber</td><td></td><td></td></tr><tr><td>History of chronic dermatitis</td><td></td><td></td></tr><tr><td>Active skin disease</td><td></td><td></td></tr><tr><td>Moles that change in size or color</td><td></td><td></td></tr><tr><td>Allergies, including hay fever (if so, to what?)</td><td></td><td></td></tr></table> |                         | Sun sensitivity          | Yes                      | No                             | Allergic dermatitis to rubber                          |                          |                              | History of chronic dermatitis |                          |  | Active skin disease  |  |  | Moles that change in size or color |  |  | Allergies, including hay fever (if so, to what?) |  |  | <div>MEDICATIONS</div> <p>List all medications (prescription and over-the-counter) you are currently taking.</p> <div></div> <div></div> <div></div> <div></div> <div>ALLERGY</div> <div></div> |
| History of psychosis   | Yes                      | No  |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Psychiatric/psychological consultation   |                          |   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Poor adaptation to stress  |                          |   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Panic attacks, hyperventilation, or anxiety or phobia disorder   |                          |   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Uncontrollable rage  |                          |   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Claustrophobia   |                          |   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Diagnosed depression, personality disorder, or neuroses  |                          |   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Sun sensitivity  | Yes                      | No  |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Allergic dermatitis to rubber  |                          |   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| History of chronic dermatitis  |                          |   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Active skin disease  |                          |   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Moles that change in size or color   |                          |   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |
| Allergies, including hay fever (if so, to what?)   |                          |   |                                  |     |  |  |                          |                           |                  |                          |  |               |                          |                          |                     |                          |                                 |                                 |                          |  |                                  |                             |   |                         |                          |                          |                                |  |                          |                              |                               |                          |  |  |  |  |                                    |  |  |  |  |  |   |

| MEDICAL HISTORY  |  |  | DIAGNOSTIC AND PHYSICAL FINDINGS  |  |  |  |
|--|--|--|---|--|--|--|
| <p align="center"><b>MUSCULOSKELETAL</b></p> <p>Moderate to severe joint paint, arthritis, tendonitis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Amputations <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Loss of use of arm, leg, fingers, or toes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Aseptic bone necrosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Loss of sensation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Loss of strength <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Loss of coordination <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chronic back pain<br/>(back pain associated with neurological deficit or leg pain) <input type="checkbox"/> Yes <input type="checkbox"/> No (check one)</p> <p>Are you RIGHT handed? <input type="checkbox"/> Yes <input type="checkbox"/> No (check one)</p> <p>Are you LEFT handed? <input type="checkbox"/> Yes <input type="checkbox"/> No (check one)</p> |  |  | <p><b><u>Musculoskeletal</u></b></p> <p>Normal Abnormal</p> <p><input type="checkbox"/> <input type="checkbox"/> Upper extremities (strength)</p> <p><input type="checkbox"/> <input type="checkbox"/> Upper extremities (range of motion)</p> <p><input type="checkbox"/> <input type="checkbox"/> Lower extremities (strength)</p> <p><input type="checkbox"/> <input type="checkbox"/> Lower extremities (range of motion)</p> <p><input type="checkbox"/> <input type="checkbox"/> Feet</p> <p><input type="checkbox"/> <input type="checkbox"/> Hands</p> <p><input type="checkbox"/> <input type="checkbox"/> Spine, other musculoskeletal</p> <p><input type="checkbox"/> <input type="checkbox"/> Flexibility of neck, back, spine, hips</p> <p>Comments/Findings</p> |  | <p><b><u>Medically cleared for the following:</u></b></p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Vigorous aerobic exercise program 3 hr/wk</p> <p><input type="checkbox"/> <input type="checkbox"/> Push ups</p> <p><input type="checkbox"/> <input type="checkbox"/> Pull ups</p> <p><input type="checkbox"/> <input type="checkbox"/> Sit ups</p> <p><input type="checkbox"/> <input type="checkbox"/> One and one half mile (1 1/2) timed run</p> <p><input type="checkbox"/> <input type="checkbox"/> 3-mile timed walk</p> <p><input type="checkbox"/> <input type="checkbox"/> Time bicycle test</p> <p><input type="checkbox"/> <input type="checkbox"/> Squat/rise w/o holding on; hold squat 45 sec.</p> <p><input type="checkbox"/> <input type="checkbox"/> Kneel on one knee, arms extended for 7 sec.</p> <p><input type="checkbox"/> <input type="checkbox"/> Assume a 1 then 2 knee kneeling position w/<br/>2 seconds, rise w/o assistance, repeat</p> |  |
| <p align="center"><b>NEUROLOGICAL</b></p> <p>Any neurological disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tremors, shakiness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Seizures (current or previous) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Spinal Cord Injury <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Numbness or tingling <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Head/spine surgery <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>History of head trauma with persistent deficits <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chronic recurring headaches (migraine) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Brain tumor <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Loss of memory <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Insomnia (difficulty sleeping) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>         |  |  | <p><b><u>Neurological</u></b></p> <p>Normal Abnormal</p> <p><input type="checkbox"/> <input type="checkbox"/> Cranial Nerves (I - XII)</p> <p><input type="checkbox"/> <input type="checkbox"/> Cerebellum</p> <p><input type="checkbox"/> <input type="checkbox"/> Motor/Sensory (include vibratory and proprioception)</p> <p><input type="checkbox"/> <input type="checkbox"/> Deep Tendon reflexes</p> <p><input type="checkbox"/> <input type="checkbox"/> Mental Status Exam</p> <p>Comments/Findings</p>   |  | <p>Comments/Findings</p>   |  |
| <p align="center"><b>GASTROINTESTINAL</b></p> <p>Hernias <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Colostomy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Persistent Stomach/Abdominal Pain/Active Ulcer disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis, or other liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Irritable bowel syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rectal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Vomiting blood <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   |  |  | <p><b><u>Gastrointestinal</u></b></p> <p>Normal Abnormal</p> <p><input type="checkbox"/> <input type="checkbox"/> Auscultation</p> <p><input type="checkbox"/> <input type="checkbox"/> Palpation</p> <p><input type="checkbox"/> <input type="checkbox"/> Organo-megaly</p> <p><input type="checkbox"/> <input type="checkbox"/> Tenderness</p> <p><input type="checkbox"/> <input type="checkbox"/> Inguinal hernia</p> <p>Attach blood chemistry panel report</p>  |  | <p>Comments/Findings</p>   |  |
| <p align="center"><b>GENITOURINARY</b></p> <p>Blood in urine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Stones <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficult or painful urination <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   |  |  | <p><b><u>Genitourinary</u></b></p> <p>Normal Abnormal</p> <p><input type="checkbox"/> <input type="checkbox"/> Urogenital exam</p> <p>Attach urinalysis report</p>  |  | <p>Comments/Findings</p>   |  |

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

## MEDICAL HISTORY

### VISION

Frequent headaches  
Blurred vision  
Difficulty reading  
Eye disease, glaucoma  
Eyeglasses  
Contact lenses  
Cataracts  
Color blindness

Yes No  
☐ ☐  
☐ ☐  
☐ ☐  
☐ ☐  
☐ ☐  
☐ ☐  
☐ ☐  
☐ ☐

Have you had any type of eye surgery (e.g., radial keratotomy, PRK [laser], cataract, etc.) If "YES", please provide **specific type and date of surgery**:

### HEARING

Loud, constant noise or music in the last 14 hours  
Loud, impact noise in past 14 hours  
Ringing in the ears  
Difficulty hearing  
Ear infections or cold in the last 2 weeks  
Dizziness or balance problems  
Eardrum perforation  
Do you use a hearing aide?  
Are you in a Hearing Conservation Program  
Do you use protective hearing equipment  
If yes, type(s): ☐ foam ☐ pre-mold/plugs ☐ ear muffs  
Have you had prior Military Service  
Have you had prior ear surgery

Yes No  
☐ ☐  
☐ ☐  
☐ ☐  
☐ ☐  
☐ ☐  
☐ ☐  
☐ ☐  
☐ ☐  
☐ ☐  
☐ ☐  
☐ ☐  
☐ ☐

MD comments on positive findings \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## DIAGNOSTIC AND PHYSICAL FINDINGS

### Head and Neck

Normal Abnormal  
☐ ☐ Head, Face, Neck (thyroid), Scalp  
☐ ☐ Nose/Sinuses/Eustachian tube  
☐ ☐ Mouth/Throat  
☐ ☐ Pupils equal/reactive  
☐ ☐ Ocular Motility  
☐ ☐ Ophthalmoscopic Findings  
☐ ☐ Speech

Comments/Findings

### Ears

Right Normal Abnormal  
☐ ☐ Canal/External ear  
☐ ☐ Tympanic Membrane  
Left  
☐ ☐ Canal/External ear  
☐ ☐ Tympanic Membrane

Comments/Findings:

### Hearing

**Audiogram:** With hearing aid? ☐ Yes ☐ No **Type:** ☐ Baseline ☐ Annual ☐ Termination (Attach current and baseline audiogram) (Note: The use of hearing aids is not acceptable for some clearance examinations, such as for law enforcement.)

Calibration Method: ☐ Oscar ☐ Biological Date

| Frequency | 500Hz | 1000Hz | 2000Hz | 3000Hz | 4000Hz | 6000Hz | 8000Hz |
|-----------|-------|--------|--------|--------|--------|--------|--------|
| Right ear |       |        |        |        |        |        |        |
| Left ear  |       |        |        |        |        |        |        |

Review/compare with baseline: No Change ☐ Mild Change ☐ Significant Threshold Shift (10 dB above or more in 2000, 3000, and 4000 Hz)  
☐ Normal ☐ Abnormal Explain:

### Vision

**Color Vision**  
Normal Abnormal Number Correct:  
☐ ☐ \_\_\_\_\_ of \_\_\_\_\_ tested  
Can see Red/Green/Yellow? ☐ Yes ☐ No  
Type of test  
☐ Ishihara plate ☐ Function test (Yarn, wire, etc.)  
☐ Other (specify \_\_\_\_\_)

### Visual Acuity

**Uncorrected vision (Snellen Units)**  
Both Near 20/\_\_\_\_\_ Right Near 20/\_\_\_\_\_ Left Near 20/  
Both Far 20/\_\_\_\_\_ Right Far 20/\_\_\_\_\_ Left Far 20/

**Corrected vision (Snellen Units)**  
Both Near 20/\_\_\_\_\_ Right Near 20/\_\_\_\_\_ Left Near 20/  
Both Far 20/\_\_\_\_\_ Right Far 20/\_\_\_\_\_ Left Far 20/

### Peripheral Vision

Right  
Nasal\_\_\_\_\_degrees Temporal\_\_\_\_\_degrees  
Left  
Nasal\_\_\_\_\_degrees Temporal\_\_\_\_\_degrees

**Depth Perception** (Type of test: \_\_\_\_\_)  
☐ Normal ☐ Abnormal Number Correct:  
\_\_\_\_\_ of \_\_\_\_\_ tested

Interpretation: \_\_\_\_\_ Seconds of Arc

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

| <b>PROFESSIONAL STAFF</b><br>Please check all the topics you discussed during the diagnostic work-up or physical examination  |   | <b>EXAMINING PHYSICIAN</b><br>Summary of Abnormal Findings with Plan of Action/Referral |
|---|---|---|
| <div> <input type="checkbox"/> Diet <input type="checkbox"/> Low-calorie <input type="checkbox"/> Low-fat <input type="checkbox"/> Low-salt </div> <div> <input type="checkbox"/> Cholesterol <input type="checkbox"/> Hypertension <input type="checkbox"/> Exercise <input type="checkbox"/> Obesity <input type="checkbox"/> Smoking Cessation <input type="checkbox"/> Avoid Sun Exposure/Sun Screen <input type="checkbox"/> Alcohol Use <input type="checkbox"/> Cancer Screening <input type="checkbox"/> Immunizations <input type="checkbox"/> Hearing Protection <input type="checkbox"/> Vision Referral <input type="checkbox"/> Other Personal Protective Equipment <input type="checkbox"/> Job Stressors <input type="checkbox"/> Referral(s) </div> <div> Others </div> | <p>The information obtained in the completion of this form is used to help determine whether an individual assigned to a job with duties that may be considered arduous or hazardous can carry out those duties in a safe and efficient manner that will not unduly risk aggravation, acceleration, exacerbation, or permanently worsening pre-existing conditions(s). The collection and use of this information is consistent with the provisions of 5 USC 552a (the Privacy Act of 1074), 5 USC 3301 and Executive Orders 12170 and 12564 (Drug Free Workplace).</p> <p>The information will be placed in you official Employee Medical File, and is to be used only for official purposes as explained and published annually in the Federal Register under OPM/GOVT-10, the Office of Personnel Management system of records notice. Your admission of this information is voluntary. If you do not wish to provide the information, you are not required to do so. However, your assignment to perform duties that are considered arduous or hazardous depends on the availability of complete and current occupational health records.</p> | <div> </div> <div> <u>Physician signature</u> </div>                                    |

#### RELEASE OF INFORMATION

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned on these forms to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I authorize the release of all medical information to the Federal Occupational Health/Law Enforcement Medical Program and on a need to know basis, the designated Park Police point of contact.

SIGNATURES

DATE

Client

Nurse

**PLEASE BE SURE ALL REQUIRED SECTIONS OF THIS FORM HAVE BEEN COMPLETED AND ARE LEGIBLE BEFORE RETURNING IT FOR REVIEW BY THE DESIGNATED MEDICAL REVIEW OFFICER.**